WASHINGTON - Following two recent hearings held by the House Veterans Affairs Subcommittee on Oversight and Investigations, Subcommittee Chairman Rep. Harry Mitchell asked for a Government Accountability Office (GAO) review of the Department of Veterans Affairs' overall quality of care. Mitchell, along with VA Full Committee Chairman Bob Filner of California and Committee members Zachary Space of Ohio and Michael Michaud of Maine, wrote to GAO Comptroller General Gene Dodaro to request the review.

"Our Veterans and those who have bravely served us deserve the best care possible," Mitchell said. "Those of us charged with Oversight of the Department of Veterans Affairs have a solemn responsibility to ensure that our veterans get the quality care they've earned. These botched procedures have let our veterans down and destroyed trust in the VA, and we must work to regain that trust. This review is a crucial step in that process."

Specifically, the letter requests that GAO examine the amount of Form 95 issuances, the consistency and quality of training for medical professionals, as well as review the peer review process, and the morbidity and mortality of patients in VA care compared to other care providers. Form 95 issuances pertain to malpractice claims filed against the VA. Recent VA responses to claims of improper treatment have not allayed veterans' fears that VA care may actually place them in danger.

The full text of the letter is below:

July 31, 2009

The Honorable Gene L. Dodaro
Acting Comptroller General of the United States
U.S. Government Accountability Office
441 G Street, NW
Washington, D.C 20548

Dear Comptroller General Dodaro:

We write to request the assistance of the Government Accountability Office (GAO) to further our efforts to address the consistency and reliability of routine care and treatment at Department of Veterans Affairs (VA) hospitals, medical centers, and clinics.

Recent high-profile reports of "botched" medical procedures such as colonoscopies, prostate cancer therapy, and vision exams have shaken the veteran community's trust in VA the healthcare system. The House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations recently held a hearing on endoscopy reprocessing, where it was suggested that private care providers would not disclose adverse events as the VA was required to do. Responses from the VA have proven unsatisfactory in assuaging veterans' fears that VA care may actually place them in danger.

We request that GAO undertake a review of the VA's overall quality of care. In so doing, we ask that you include an examination of the following: the amount of Form 95 issuances; the consistency and quality of training for medical professionals; a review of the peer review process, and the morbidity and mortality of patients in VA care compared to other care providers. We further request that you take into consideration the geographic concentration of incidents and the relative quality of care experienced by rural vs. non-rural veterans.

Thank you for your assistance on this matter. If you have any questions, please feel free to

contact Martin Herbert, Staff Director of the Subcommittee on Oversight and Investigations, at (202) 225-3569.

Sincerely,

BOB FILNER
Chairman,
House Committee on Veterans' Affairs

HARRY E. MITCHELL
Chairman,
Subcommittee on Oversight and Investigations

MICHAEL H. MICHAUD
Chairman,
Subcommittee on Health and Investigations

ZACHARY T. SPACE
Member,
Subcommittee on Oversight and Investigations